2020-2021 PRE-K Registration Roundup
At Union County Primary School

Bright from the Start and Union County Schools meet the child-care and early education needs of Georgia's children and their families by providing a daily quality and fun learning environment. The Union County Pre-K Program is open to any four-year-old child who loves to play and learn! Children who will be **four years old on or before September 1, 2020** are eligible to enroll. Our Pre-K program prepares children for Kindergarten and beyond. The Pre-K classes are located in the primary school and transportation is provided, if needed.

Union County Primary School will take **calls for registration appointments beginning January 27th**. Available Pre-K seats will be filled on a first-come first-served basis.

Face-to-Face registration appointment sessions will take place from **March 2nd to March 4th**. The **appointments** will be scheduled between **9:00 AM and 2:40 PM.**

Registration can be expedited if parents complete an enrollment packet prior to their appointment. A copy of the enrollment packet is available on the school system's website at www.ucschools.org, the Primary School front office or the Board of Education office.

A parent or legal guardian is required to be at the registration appointment and bring the following items:

- Completed **Enrollment Packet**
- Certified copy of student's **Birth Certificate** ***(Mandatory at time of registration)***
- Student's **Social Security card**
- **Immunization Certificate:** ***Current*** Georgia Department of Human Resources immunization record (Form 3231) **Note:** Out of State Immunization Records will need to be taken to your GA primary care physician or Union County Health Department to be transferred to a Georgia Immunization Certificate (Form 3231) ***prior to the registration appointment.***
- **Certificate of Vision, Hearing, Dental, and Nutrition Screening (Form 3300):** This form is included in this packet and can also be obtained from your child's doctor or from the Union County Health Department. Please take this form to your doctor before your child comes to school.
- **Proof of Union County Residency (2 documents)**
  Examples include: Current (within 2 months old) lease agreement, vehicle registration form, mortgage documents, property tax notice, homeowner's insurance bill, utility bills, etc. A cellphone bill, driver's license, or bank statement are not acceptable.

All required forms and documents must be submitted at time of registration. A student will not be enrolled if any documents are missing and the student will be placed on the waiting list.

Documentation for Homeless Students

Homeless students, as defined by the McKinney-Vento Act, shall be enrolled immediately with full participation in school activities, regardless of whether all of the above can be provided at the time of enrollment. The designated employee responsible for care of homeless students shall assist the person enrolling the homeless student or the unaccompanied youth in acquiring the necessary documents for enrollment in accordance with the requirements of the state enrollment rule and the McKinney-Vento Act.

Parents are welcome to contact the Primary School Office (706-835-4321) for answers to any questions you may have regarding the Pre-K registration.

Union County School System, in its enrollment procedures, requirements and process
does not and will not discriminate based on race, color, national origin, or immigration status.

An Equal Opportunity Educational Provider and Employer

Union County Schools—Student Registration Information

Please Print **Please Print** **Please Print**

Student Legal Name: ______________ Last ______________ First ______________ Middle ______________ Preferred

SSN: _______ - _____ - _______ ☐ Male ☐ Female Date of Birth: ______________ Grade: ________

Phone: ______________ Best Contact Number Place of Birth: ________ City ________ County ____ State ________ Country

Phone Number For Text Messages: ____________ Alternate Phone Number for Text Messages: ____________

If student was born in another country, has he/she attended 3 full years of school in the United States? ☐ Yes ☐ No ____________ Date Entered U.S. Schools (If born in another country)

Ethnicity: Is student Hispanic or Latino? (Choose only one) ☐ No, not Hispanic or Latino ☐ Yes, Hispanic of Latino
(A person from Cuba, Mexico, Puerto Rico, South or Central American Countries, or other Spanish Culture or Origin, regardless of Race)

What is student's race? (Choose one or more)

☐ **American Indian or Alaskan Native**
(A person having origins in any of the original of peoples of North and South America (including Central America), and who maintains tribal affiliations or community attachment)s.

☐ **Native Hawaiian or Other Pacific Islander**
(A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or Other Pacific Islands.)

☐ **Asian**
(A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ **Black or African American**
(A person having origins in any of the black racial groups of Africa.)

☐ **White**
(A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Home Address: ______________ Street ________ City ____ State ________ Zip Code ________ County

Mailing Address: ______________ P.O. Box / Street ________ City ____ State ________ Zip Code ________ County
(If different from above)

Father's Name: ______________ Employer: ______________

Home Phone: ________ Day/Work: ________ Cell: ________ E-mail: ______________

Mother's Name: ______________ Employer: ______________

Home Phone: ________ Day/Work: ________ Cell: ________ E-mail: ______________

Single Parent Household ☐ Yes ☐ No

Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Grandparents ☐ Other: Specify ________

Guardian's Name: ______________ Employer: ______________

Home Phone: ________ Day/Work: ________ Cell: ________ E-mail: ______________

Guardian's Relationship to Student: ______________

Language at Home: (example: English, Spanish, French)

SPOKEN ______________ **WRITTEN** ______________

(01/2019)

Union County Schools—Student Registration Information

Emergency Contacts: The following people may be contacted, if the school system is unable to contact parent/guardian.
NOTE: If any of these may need to pick-up your child, they will need to be listed on the section below.
"Persons Authorized to Pick-up / Sign-out Student"

Emergency Contact #1: ______________________________

Phone: ____________ Alternate Phone: ____________ Relationship: ____________

Emergency Contact #2: ______________________________

Phone: ____________ Alternate Phone: ____________ Relationship: ____________

Emergency Contact #3: ______________________________

Phone: ____________ Alternate Phone: ____________ Relationship: ____________

Persons Authorized to Pick-up / Sign-out Student:
(Don't Forget to Include Yourself)

The following adults may pick-up / sign-out student without the school contacting the parent/guardian for permission.

Name	Relationship to Student

To School Transportation: ☐ Bus ☐ Parent ☐ Rides w/Someone Other Than Parent ☐ Student Drives

If Known: Bus #: ________ Bus Driver: ____________________

From School Transportation: ☐ Bus ☐ Parent ☐ Rides w/Someone Other Than Parent ☐ Student Drives

If Known: Bus #: ________ Bus Driver: ____________________

Early/Emergency Dismissal Plan:
(How will the student go home in the case of an early school closing?)

Check & Complete Only One Option.

☐ Ride Regular Bus Bus # / Driver ____________________

To: ____________ Address: ____________________

☐ Ride Different Bus Bus # / Driver ____________________

To: ____________ Address: ____________________

☐ Parent Will Pick-up ☐ Will Be Picked-up By: ____________________

☐ Other: ____________________

(01/2019)

Union County Schools—Student Registration Information

Medical Information:

Allergies: ______________________________

Other Medical Considerations: ______________________________

Medical Alerts: ______________________________

Current Medications: ______________________________

Pre-K Program Student Attended:

☐ GA Pre-K ☐ Publicly Sponsored ☐ Head-Start ☐ Other Public School
☐ Private-Non-Profit ☐ Private For Private ☐ Did Not Attend a Pre-K

Pre-School Name: ______________________________ City, State: ______________________________

Has student ever been Home-schooled? ☐ Yes ☐ No

Has student ever attended Union County Schools? ☐ Yes ☐ No If yes, which grades and years? ______________________________

Has student ever repeated a grade? ☐ Yes ☐ No If yes, which grade(s) and why? ______________________________

Is student enrolled in Special Ed. Program? ☐ Yes ☐ No If yes, which one? ______________________________

Has student ever had a psychological evaluation? ☐ Yes ☐ No If yes, when was it completed? ______________________________

Primary School Students Only:
Please explain any complications during the pregnancy / birth or any delays in the early development. ______________________________

____

Has the student ever had any experience that might have upset him/her emotionally or is there any other milestones regarding the student that you would like to share with us that may help us know and serve him/her more effectively?

____

Please provide information for the school the student most recently attended, so we may request educational records.

School Name: ______________________________

Address: ______________________________ City: ______________ State: ______ Zip: __________

****************************** **WITHDRAWAL INFORMATION** ******************************

The individual enrolling a student is the only person permitted to withdraw the student.

Enrolling Parent

The person who enrolls a student during the school year assumes parental status; this can be mother or father (or both), a legal guardian, or any other person who has assumed the role of parent. Pursuant of GA Law, the enrolling parent(s) is the only individual(s) allowed to add to, delete from, or alter a student's pick-up list.

I verify that all of the above information is correct and accurate. I understand that it shall be my responsibility to notify the school of any changes. Furthermore, I understand my signature below assigns me (and designated other listed below) as the school system's enrolling parent for the above named student.

______________________________ ______________________________ ______________
Enrolling Parent Printed Name Enrolling Parent Signature Date

______________________________ ______________________________ ______________
Optional Additional Enrolling Parent Printed Name **Optional** Additional Enrolling Parent Signature Date

Union County School System
Consent for School Health Services

Please read, complete, sign, date & return to the school within 3 days. If you have any questions before signing, please contact the school. This consent form must be completed and signed by the parent or guardian in order for your child to receive services from the nurse. Without your consent, we will not be able to give your child minor or emergency treatments.

Student's Last Name	First Name	Birthdate	Grade	Homeroom

Student's Doctor:______________________________ Phone #______________

Parent/Guardian:______________________________ Home Phone #______________

Address:____

Work phone:______________________________ Cell Phone #______________

PAST MEDICAL HISTORY	YES/NO	IF YES, EXPLAIN
Allergies (drugs or food)	___/___	
Current Medications	___/___	
Diabetes	___/___	
Seizure Disorder	___/___	
Asthma	___/___	
Wears Contact Lens	___/___	
Mental Illness	___/___	
Previous Surgery	___/___	
Previous Hospitalizations	___/___	
Other Illness	___/___	

Below is a list of medicines that the nurse might use on or give to your child. Please circle any medicines that you <u>DO NOT</u> want your child to receive. If you wish for your child to receive Tylenol, Advil, or any other medicines while at school, you will need to provide the medicine and complete the Authorization of Medication form for that medicine.

<u>Sore Throat:</u>	Sore Throat Spray	<u>Rash/Insect Bites:</u>	Hydrocortisone cream
	Warm Salt Gargle		Benadryl cream/Spray
<u>Eyes:</u>	Visine		Caladryl
	Eye wash	<u>Cuts/Scrapes:</u>	Bactine/Hibiclens
<u>Mouth:</u>	Vaseline		Dermaplast/Solarcaine
	Anbesol/Orabase		Antibiotic Ointment
<u>Mild Stomach Upset:</u>	Antacid/ Tums	Head/Body Aches	Tylenol/Ibuprofen

Should my child suffer an accident while at school, Union County School System has permission to transport my child to the nearest health care facility in case of my absence.

I give permission for the above named student to receive services from the School Health Clinic. I understand that all services are free and confidential. I have given accurate and complete information to the best of my knowledge.

This consent is in effect for the current school year or until the parent otherwise notifies the school.

Signature of Parent/Guardian   **Relationship**   **Date**

OR

No, <u>I do not</u> want the above student to receive services or have access to the School Clinic.

Signature of Parent/Guardian   **Relationship**   **Date**

Georgia Department of Education
ESOL & Title III Unit

Georgia Department of Education

Required Home Language Survey

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she speaks and understands English. This survey assists school personnel in deciding whether your child may be a candidate for additional English language support. Final qualification for language support is based on the results of an English language assessment.

Thank You

Student Name (required information):

____

Language Background (required information):

1. Which language does your child best understand and speak?

   ____

2. Which language does your child most frequently speak at home?

   ____

3. Which language do adults in your home most frequently use when speaking with your child?

   ____

Language for School Communication (not required):

4. In which language would you prefer to receive all school information?

   ____

______________________________ ______________

Signature of Parent/Guardian/Other **Date**

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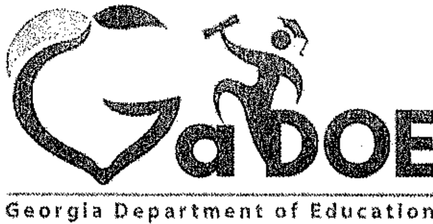

Richard Woods, Georgia's School Superintendent
"Educating Georgia's Future"

School District:____________________ **Date:**____________________

Parent Occupational Survey
Please complete this form to determine if your child(ren) qualify to receive supplemental services under Title I, Part C

Name of Student(s)	Name of School	Grade

1. Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years? ☐ **Yes** ☐ **No**

2. Has anyone in your household been involved in one of the following occupations, either full or part-time or temporarily during the last three (3) years? ☐ **Yes** ☐ **No**

   If you answer "yes", check all that applies:
   - ☐ 1) Planting/picking vegetables (such as tomatoes, squash, onions) or fruits (such as grapes, strawberries, blueberries)
   - ☐ 2) Planting, growing, cutting, processing trees (pulpwood), or raking pine straw
   - ☐ 3) Processing/packing agricultural products
   - ☐ 4) Dairy/Poultry/Livestock
   - ☐ 5) Meatpacking/Meat processing/Seafood
   - ☐ 6) Fishing or fish farms
   - ☐ 7) Other (Please specify occupation): ____________________

Names of Parent(s) or Legal Guardian(s) ____________________

Current Address: ____________________

City: ____________ **State:** ________ **Zip Code:** ________ **Phone:** ____________

Thank You!
Please return this form to the school

Please maintain original copy in your files.
MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.
Non-MEP funded (consortium) school/districts: When at least one "yes" **and** one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, P.O. Box 780, 201 West Lee Street, Brooklet, GA 30415
Toll Free (800) 621-5217 **Fax (912) 842-5440**

GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637
Toll Free (866) 505-3182 **Fax (229) 546-3251**

Regional Office use only: ☐

Georgia Department of Public Health
Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

Parent/ Guardian Name:______________________________
first middle last

Parent/ Guardian Contact Information:

Daytime phone number:______________________________

Evening phone number:______________________________

Cell phone number:______________________________

Child's Name:______________________________
first middle last

Date of Birth: _____/_____/_____ **Gender:** ❑**Male** ❑**Female**

Child's Home Address:

____
street city state zip code county

VISION

- ❑ Unable to screen (explain why below)
- ❑ Uses corrective lenses
- ❑ Worn for testing
- ❑ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
- ❑ Needs further evaluation
- ❑ Under professional care (explain below)

Screening completed by:

- ❑ Physician
- ❑ Local Health Department
- ❑ Optometrist
- ❑ "Prevent Blindness Georgia" employee
- ❑ School Registered Nurse

____
Screener's Signature Date
I certify that this child has received the above screening.
Contact Information:

HEARING

- ❑ Unable to screen (explain why below)
- ❑ Uses hearing aid / assistive device
- ❑ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
- ❑ Needs further evaluation
- ❑ Under professional care (explain below)

Screening completed by:

- ❑ Physician
- ❑ Local Health Department
- ❑ Audiologist
- ❑ Speech-Language Pathologist
- ❑ School Registered Nurse

____
Screener's Signature Date
I certify that this child has received the above screening.
Contact Information:

DENTAL

- ❑ Unable to screen (explain why below)
- ❑ Normal appearance
- ❑ Needs further evaluation
- ❑ Emergency problem observed
- ❑ Under professional care (explain below)

Screening completed by:

- ❑ Physician
- ❑ Dentist
- ❑ Local Health Department Registered Nurse
- ❑ Registered Dental Hygienist
- ❑ School Registered Nurse

____
Screener's Signature Date
I certify that this child has received the above screening.
Contact Information:

NUTRITION

- ❑ Unable to screen (explain why below)

Height: __________ Weight: __________

BMI: __________ BMI%: __________

- ❑ 5th to 84th percentile - Appropriate for age
- ❑ < 5th percentile - Needs further evaluation
- ❑ ≥ 85th percentile - Needs further evaluation
- ❑ Under professional care (explain below)

Screening completed by:

- ❑ Physician
- ❑ Local Health Department
- ❑ Registered Dietician
- ❑ School Registered Nurse

____
Screener's Signature Date
I certify that this child has received the above screening.
Contact Information:

FOR SCHOOL SYSTEM ONLY Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
Vision			
Hearing			
Dental			
Nutrition			

Student support services initiated on:

Screeners' Comments:

Georgia Department of Public Health Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

Who is required to file this Form 3300? The parent or guardian of a child who is being admitted for the first time to a public school in Georgia must file a completed Form 3300 with the school when the child is enrolled.

What is the purpose of Form 3300? Form 3300 is intended to make sure that every child in Georgia is screened for possible problems with their vision, hearing, teeth and nutrition. The earlier these problems are detected, the earlier parents can seek professional help for the child.

What screenings are required? Four different screenings are required: vision, hearing, dental, and nutrition. All four screenings must be conducted and reported on the form before it can be filed with the school.

Who can conduct the screenings? Your child's doctor is authorized to conduct all four screenings, as is your local health department. In addition, the vision screening can be conducted by a Georgia licensed optometrist, an employee of Prevent Blindness Georgia trained to conduct vision screening, or a school registered nurse; the hearing screening can be conducted by a Georgia licensed speech-language pathologist or audiologist, or a school registered nurse; the dental screening can be conducted by a Georgia licensed dentist, dental hygienist, or a school registered nurse; and the nutrition screening can be conducted by a Georgia licensed dietician or a school registered nurse. It is not necessary that the same person conduct all four screenings.

What does "BMI" and "BMI%" mean? "BMI" means "body mass index." BMI is a way to describe how much a child weighs in relation to height. "BMI percentile" is a way to compare the child's body mass index to the body mass index of a healthy child. If the child's BMI is less than 5% or more than 84% of what is appropriate for his or her age and height, then the child should be taken to a doctor or dietician for a more detailed evaluation. For more information, visit the Centers for Disease Control and Prevention website on child and teen BMI at:

http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

What should a parent do if the "needs further evaluation" box is checked? "Needs further evaluation" means that the child may have a problem. If the "needs further evaluation" box is checked, then the parent should take the child to a professional for a more detailed evaluation. Your doctor or local health department may be able to help, or recommend someone who can help.

What if a Form 3300 was previously filed for the child at another school? It is only necessary to file the Form 3300 once. If the Form 3300 is filed at the child's first school, and the child later transfers to another school, then the original school is required to forward the Form 3300 to the new school.

Georgia's Pre-K Program 2019-2020
Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate. *(Por favor escriba el nombre como aparece en el certificado de nacimiento.)*

Legal Last Name *(Apellido)*		
Legal First Name *(Primer Nombre)*		
Legal Middle Name *(Segundo Nombre)*		Name Suffix *(Sufijo)* (Jr,II,III)
Child's Social Security #	DOB *(Fecha de Nacimiento)* (M/D/Y)	Gender *(Sexo)*
______ -- ______-- ______	_____/_____/_____	☐ M ☐ F
Date enrolled in Pre-K (M/D/Y)	**If different from birth certificate, name student is called**	
08 / 12 / 2020		

1. Is your child's ethnicity **Hispanic/Latino/Spanish Origin,** regardless of race? *(¿Es Ud.* ***Hispano/Latino o de Origen Hispano,*** *sin importar la raza?)*

☐ **Yes** *(Si)* ☐ **No** *(No)* ☐ **Decline to Answer** *(negarse a contester)*

Please select <u>ONE OR MORE</u> of the following races regardless of how you answered question one. *(<u>TODOS</u> deben seleccionar <u>UNA O MAS</u> de las siguientes razas sin importar cómo haya contestado la primera pregunta.)*

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. *(**Blanco** – Una persona que tiene orígenes en los pueblos provenientes de Europa, el Medio Oriente, o Africa del Norte).*

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *(**Asiática** – Una persona con orígenes en los pueblos provenientes del Lejano Oriente, Suroeste de Asia, o el subcontinente Hindú incluyendo, a Cambodia, China, India, Japón, Corea, Malasia, Pakistán, Las Filipinas, Tailandia, y Vietnam.)*

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. *(**Nativo de Hawaii u Otra Isla del Pacífico** – Una persona con orígenes en los pueblos provenientes de Hawaii, Guam, Samoa, u otra Isla del Pacifico.)*

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa. *(**Negro o Afro Americano** – Una persona con orígenes en los pueblos provenientes del Africa o en grupo racial Negro.)*

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment. *(**Indio Americano o Nativo de Alaska** – Una persona con orígenes en los pueblos provenientes de América Del Norte y del Sur, incluyendo América Central, que mantiene una afiliación tribal o comunitaria.)*

☐ f. **Decline to Answer** *(negarse a contester)*

3. What is your child's primary language? *(¿Cuál es el idioma primario de su hijo(a)?)*

☐ **English** *(Inglés)*

☐ **A language other than English** *(Un idioma diferente al Inglés)*

4. Was your child born as a: *(El parto en que Ud. tuvo a su hijo(a) fue de:)*

☐ **Single Birth (1)** *(Un sólo niño)*

☐ **Twin (2)** *(De mellizos)*

☐ **Triplet (3)** *(De trillizos)*

☐ **Quadruplet (4)** *(De cuatrillizos)*

☐ **Quintuplet (5)** *(De quintuples)*

5. Does your child have an Individualized Education Plan (IEP)? *(¿Tiene su hijo(a) un Plan de Educación Individualizada (IEP?))*

☐ **Yes** *(Si)* ☐ **No** *(No)*

6. Does your child receive any of the following services? *(¿Recibe su hijo(a) alguno de estos servicios?)*

☐ **Childcare and Parent Services (CAPS) (child care subsidy program)**

☐ **Food Stamps** *(Cupones de Alimentos)*

☐ **SSI**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

7. Will the Pre-K center be providing transportation for your child? *(¿Recibirá su hijo(a) transporte en el Centro donde va a asistir a Pre-K?)*

☐ **Yes** *(Si)* ☐ **No** *(No)*

Parent/Guardian Signature **Date**

Please write the school year in the box →

Pre-K Registration Form

2020-2021 **School Year**

PROVIDER LEGAL NAME:	(This section to be completed by the provider)
SCHOOL/SITE NAME:	

CHILD INFORMATION (Please print name exactly as it appears on the birth certificate.)			
CHILD'S LAST NAME:			
CHILD'S FIRST NAME:			
CHILD'S MIDDLE NAME:	NAME SUFFIX: (i.e. Jr, Sr, II,III)		
CHILD'S SOCIAL SECURITY#:	D.O.B. (MM/DD/BY):	SEX: [ ]M [ ]F	
HOME ADDRESS (*Do not enter PO Box Info*):		COUNTY:	
CITY:	STATE: GA	ZIP:	HOME PHONE: ( )

If the Student is transferring from another Pre-K, please provide the following:
Previous School Name: ______________________ Last Date in Attendance: __________

PARENT/GUARDIAN INFORMATION		
Parent/Guardian #1 - LAST NAME:	FIRST:	MIDDLE INITIAL:
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	
Email Address:		
Place of Employment:	Work Phone: ( )	
Address:		
City:	State:	Zip:
Parent/Guardian #2 - LAST NAME:	FIRST:	MIDDLE INITIAL:
Home Address (*If different from child*):		
City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	
Email Address:		
Place of Employment:	Work Phone: ( )	
Address:		
City:	State:	Zip:

EMERGENCY CONTACT INFORMATION (Persons to contact in the event that either parent/guardian cannot be contacted)

	NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1.					
2.					

I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in Georgia's Pre-K Program, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without appropriate age documentation. I have attached a copy of appropriate age documentation to this registration form.

Signature Parent/Guardian: ______________________ **DATE**: __________

CHILD MAINTENANCE

CHILD'S LIVING ARRANGEMENTS: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER

CHILD'S LEGAL GUARDIAN: [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER

THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:

NAME	ADDRESS	RELATIONSHIP	CELL PHONE
1.			
2.			
3.			
4.			

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): ____________________

DATE OF LAST FULL HEALTH SCREENING:____________________ PHONE: ( )

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:

MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS:

GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

SIGNATURE (Parent/Guardian): ____

DATE: ____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, ______________________________, by photograph and/or videotape in connection with daily Pre-K activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

PRE-K PROVIDER NAME/ADDRESS: ____

SIGNATURE (Parent/Guardian): ____

DATE: ____

Parental Agreements with Child Care Facility

The ____
(Name of Facility)

agrees to provide child care for ____
(Name of Child)

on ____, beginning at __________AM
(Days of Week)

and ending at ____________ PM from _________________ to _________________.
(Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast Morning Snack Lunch Afternoon
Snack

Evening Snack Dinner Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: Date, Name of Child, Name of Medication, Prescription Number (if any), Dosages, and Date and Time of Day to be given to child. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person(s) authorized by parent(s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans, and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

____ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I'm not available.

I have received a copy and agree to abide by the policies and procedures for the above-named facility.

SIGNED: ____________________________________ ____________________
Parent/Guardian Date

SIGNED: ____________________________________ ____________________
Facility Administrator / Authorized Person Date

Dear Parents,

This optional form is being provided for you to complete on your child regarding his/her placement for next year. We must consider various factors in classroom placements including class size, boy/girl ratio and the needs of students, personalities of students and teachers and student separations. Other factors considered for placement include gifted, early intervention program and special education qualifications. Please refrain from asking for a specific teacher due to consideration listed above.

****

Student's name____________________________________ Grade **2020-2021** __________

Please answer the following questions concerning your child's placement:

Are there any students with whom your child should not be placed?
(Only 2 can be honored)

1. ______________________________________ Reason: ___________________________

2. ______________________________________ Reason: ___________________________

Is there one teacher with whom your child should not be placed? (Only 1 can be honored)

1. __________________________________ Reason ________________________________

List any other concerns/thoughts regarding your child's placement:

____

Name of parent/guardian completing form (Print): ________________________________

Signature of parent/guardian completing form: ____________________________________

Please return this form to your child's teacher (or turn in at Pre-K/Kdg. Registration) in a **sealed envelope** addressed to Millie Owenby before **May 22nd, 2020.**
Thank you for your input regarding your child's placement next year.